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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
07043  
07040  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>KENT</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rock Hall</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>KENT</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rock Hall</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ELMA Rebecca ATKINSON</b> First Middle Last				4. DATE OF DEATH <b>MAY 9 1966</b> Month Day Year			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 13 - 1887</b> Yrs. Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Kent Co. MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>BIGELOW</b>				14. MOTHER'S MAIDEN NAME <b>TOLSON</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <b>MRS. WILLARD ASHLEY - ROCK HALL, MD.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardio Vascular - Hypertension</b> DUE TO (c) <b>Arterio Sclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Rock Hall Md</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>May 10 1966</b> , to <b>May 11 1966</b> , that (I) (we) last saw the deceased alive on <b>May 10 1966</b> , and that death occurred at <b>2:00 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Norbert C. Nitsch</b>				22b. DATE SIGNED <b>5/11/66</b>		22c. PHYSICIAN'S NAME (Type) <b>NORBERT C. NITSCH</b>	
22d. ADDRESS <b>Rock Hall MARYLAND</b>				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MAY 12</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wesley CHAPEL</b>		23d. LOCATION (City, town or county) (State) <b>Rock Hall MD.</b>	
24. FUNERAL DIRECTOR <b>Edgar L. Lane</b>				25a. REC'D BY REGISTRAR <b>MAY 17 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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CERTIFICATE OF DEATH

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07041

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> c. LENGTH OF STAY IN 1b <b>21 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kent &amp; Queen Anne's Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Still Pond</b> d. STREET ADDRESS <b>None</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Samuel Lester Coleman</b>		4. DATE OF DEATH Month Day Year <b>5 18 1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/29/1888</b>
9. AGE (In years lost birthday) yrs. <b>77</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Balto. Transit Co.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Kent Co., Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Samuel Coleman</b>	
14. MOTHER'S MAIDEN NAME <b>Amanda Mitzel</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>214-03-7823</b>		17. INFORMANT <b>Hospital Records</b> Address <b>Chestertown, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of lung</b> DUE TO (b) <b>163X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pharyngitis</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>5 4/27</b> , 19 <b>66</b> , to <b>5/18</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5/18</b> , 19 <b>66</b> , and that death occurred at <b>40 P.M.</b> , from causes and on the date stated above.	
22a. SIGNATURE <b>Dr. A. C. Dick</b>		22b. DATE SIGNED <b>5-18-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. A. C. Dick</b>		22d. ADDRESS <b>Chestertown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5-22-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>STILL POND,</b>		23d. LOCATION (City or Town) (County) (State) <b>STILL POND, KENT, MD.</b>	
24. FUNERAL DIRECTOR <b>Victor N. Kennedy</b>		25a. REC'D BY REGISTRAR <b>MAY 23 1966</b>	
ADDRESS <b>STILL POND, MD</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

07041

07041

NAME: \_\_\_\_\_

RESIDENCE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

EDUCATION: \_\_\_\_\_

RELIGION: \_\_\_\_\_

INDUSTRY: \_\_\_\_\_

REASON FOR VISIT: \_\_\_\_\_

DATE OF DEPARTURE: \_\_\_\_\_

*[Handwritten signature]*

REMARKS: \_\_\_\_\_

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

07051

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07042

1. PLACE OF DEATH a. COUNTY <b>KENT</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NR. MILLINGTON</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>QUEEN ANNE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NR. CENTREVILLE</b> 17-2 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>PERCY</b> First <b>EDWARD</b> Middle <b>DEWSBURY</b> Last 4. DATE OF DEATH <b>MAY</b> 9 1966				5. SEX <b>MALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>DEC. 5 - 1884</b> 9. AGE (In years last birthday) <b>81</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <b>ENGLAND</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>EDWARD DEWSBURY</b> 14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <b>218-05-8211</b> 17. INFORMANT <b>P. EDWARD DEWSBURY JR.</b> Address <b>CENTREVILLE MD.</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> several years 4331 DUE TO (b) <b>Atrial fibrillation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Arteriosclerotic cardiovascular disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>4/4</b> , <b>12 noon</b> to <b>5/9</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5/9</b> , 19 <b>66</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.				22a. SIGNATURE <b>[Signature]</b> 22b. DATE SIGNED <b>5/11/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>ROBERT W. FARR</b> 22d. ADDRESS <b>CHESTERTOWN MD.</b>				23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 23b. DATE THEREOF <b>MAY 11</b> 23c. NAME OF CEMETERY OR CREMATORY <b>CHESTER</b> 23d. LOCATION (City, town or county) (State) <b>CHESTERTOWN MD.</b>			
24. FUNERAL DIRECTOR <b>Edgar L. Lane</b> ADDRESS <b>CHURCH HILL MD.</b> 25a. REC'D BY REGISTRAR <b>MAY 17 1966</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>							

MEDICAL CERTIFICATION

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07052

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

07043

Item 1d Film C377 6/6/66 mb

1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Millington. Rural</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>At Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Kent.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chesterville</b> d. STREET ADDRESS <b>14-1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Harry R. Duckery.</b>		4. DATE OF DEATH Month <b>May,</b> Day <b>27,</b> Year <b>19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February, 21, 1906</b>	9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William E. Duckery</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>220-03-0685</b>		17. INFORMANT <b>Violetta Duckery, Millington, Md. 21651</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Coronary Occlusion (Acute)</b> DUE TO (b) <b>Arteriosclerotic Heart Dis.</b> DUE TO (c) <b>15yrs.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>5-10</b> , 19 <b>66</b> , to <b>27 May</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5-24</b> , 19 <b>66</b> and that death occurred at <b>M</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>John J. Razzori</b>		22b. DATE SIGNED <b>31 May 66</b>			
22c. PHYSICIAN'S NAME (Type) <b>John J. Razzori</b>		22d. ADDRESS <b>Smymrna, Dela.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May, 31, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>	
23d. LOCATION (City, town or county) <b>Rural Millington, Md.</b>					
24. FUNERAL DIRECTOR <b>Edward Bellows, Millington, Md.</b>		25a. REC'D BY REGISTRAR <b>JUN 1 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge.</b>	

1948

William L. Harkness

Chattanooga, Tenn.

Dear Sir:

Enclosed

is a copy of the

report of the

committee on

the subject of

the proposed

amendment to the

constitution of the

state.

I am sure that you will find the report of interest.

Very respectfully,  
William L. Harkness

Enclosed for you are two copies of the report.

I am, Sir, very truly,  
Your obedient servant,  
William L. Harkness

W. L. Harkness  
Chattanooga, Tenn.



07053

CERTIFICATE OF DEATH

07044

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN 1b <b>19 hours</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kent &amp; Queen Anne's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Raymond</b> Middle <b>NMN</b> Last <b>Garnett</b>		4. DATE OF DEATH Month <b>5</b> Day <b>27</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/7/1900</b>
9. AGE (In years lost birthday) yrs. <b>66</b>		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>27</b> Hours <b>19</b> Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Kent Co., Maryland</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>US</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>SOHN GARNETT</b>		14. MOTHER'S MAIDEN NAME <b>SOLIA WILSON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>YES</b>	
17. INFORMANT <b>Hospital Records</b>		Address <b>Chestertown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Prostate</b> <b>177X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5/26, 19 66</b> , to <b>5/27/66</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5/27</b> , 19 <b>66</b> , and that death occurred at <b>6:00 A.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. A. T. Keefe</b>		22b. DATE SIGNED <b>5/27/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. A. T. Keefe</b>		22d. ADDRESS <b>Chestertown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>5/29/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Pond Town Cem.</b>	23d. LOCATION (City or town) (County) (State) <b>(NEAR) Millington, Md</b>
24. FUNERAL DIRECTOR <b>Charles Judge</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>JUN 1 1966</b>	

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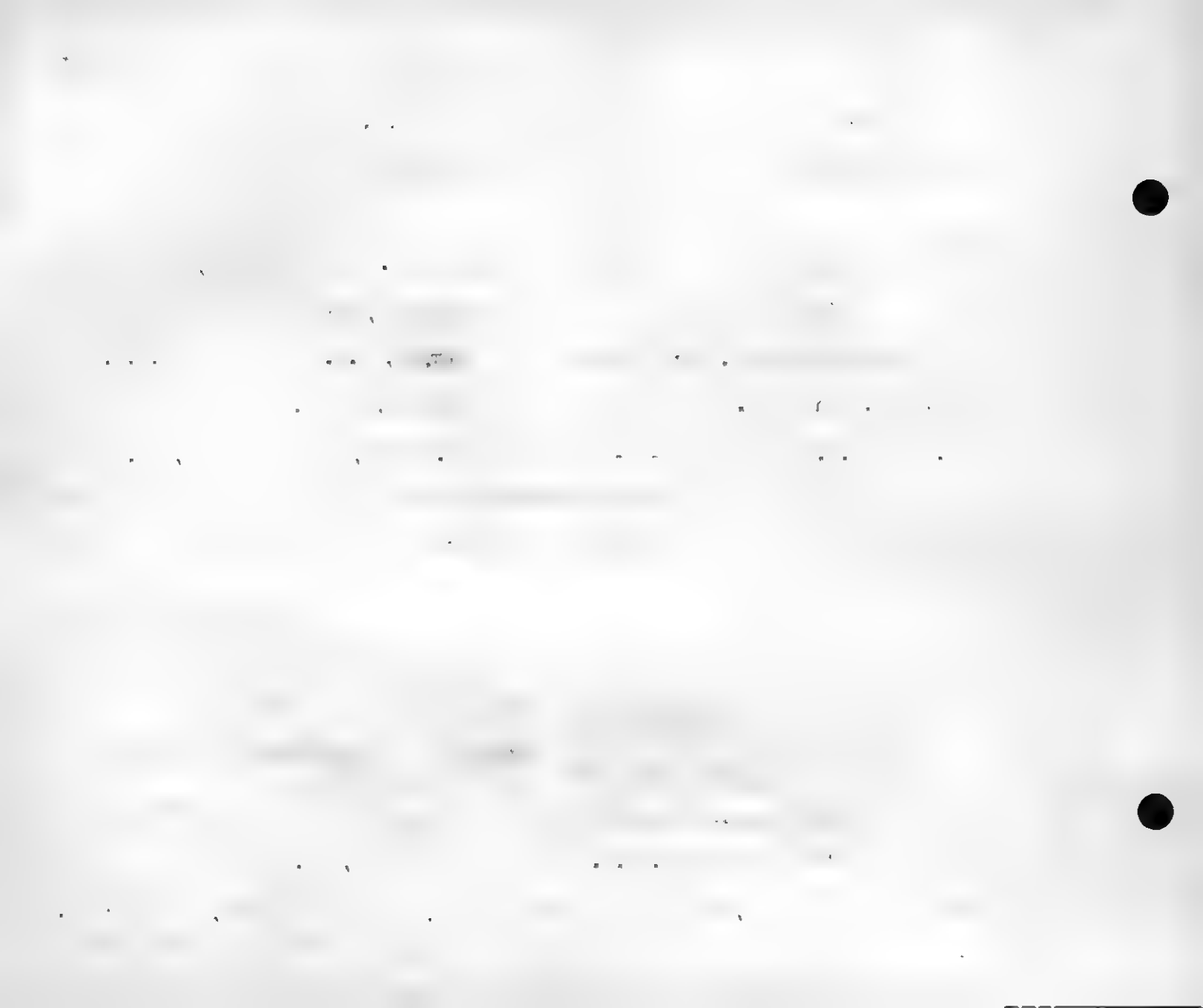
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Millington</b> c. LENGTH OF STAY IN 1b <b>Millington</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millington</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Corbitt</b> Last <b>Jones Jr.</b>		4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 7, 1893</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Wall Paper Hanger Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wall Paper</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Camden, N.J.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William C. Jones Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Jennie M. Baker.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes.</b>		16. SOCIAL SECURITY NO. <b>W.W.1 219-14-2661</b>	
17. INFORMANT <b>James R. Jones,</b>		Address <b>Millington, Md. 21651</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary sclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED <b>While</b> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Apr. 3, 1964</b> to <b>May 7, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 6, 1966</b> , and that death occurred at <b>8 P</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Geza Koralewski</b>		22b. DATE SIGNED <b>5-7-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Geza Koralewski. M.D.</b>		22d. ADDRESS <b>Millington, Md. 21651</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 10, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Millington Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Millington, Kent Co; Md.</b>	
24. FUNERAL DIRECTOR <b>Edward Bellows, Millington, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 11 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Kent</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>N Chestertown</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Kent</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kent &amp; Queen Anne's Hospital</b>				e. STREET ADDRESS <b>Rt. #1, Box 187</b>			f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <b>Frances</b>		Middle <b>Gladys</b>		Last <b>Lively</b>		4. DATE OF DEATH Month <b>May</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/10/05</b>		9. AGE (In years last birthday) <b>60 61</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Kent Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Hynson</b>				14. MOTHER'S MAIDEN NAME <b>Ida Louise Townsend</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Overwhelming infection</b> DUE TO (b) <b>Cholelithiasis &amp; cholelithiasis</b> DUE TO (c) <b>Pulmonary edema due to myo. decomp?</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cholelithiasis</b> (b) <b>Excessive obesity</b>								INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>Unknown</b> <b>? months</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5-3</b> , 1966, to <b>5-5</b> , 1966, that (I) (we) last saw the deceased alive on <b>5-5</b> , 1966, and that death occurred at <b>5 P.</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>Harry P. Ross</b>						22b. DATE SIGNED <b>5-6-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Harry P. Ross</b>						22d. ADDRESS <b>Chestertown, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5/9/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. GEORGE CEM</b>		23d. LOCATION (City, town or county) (State) <b>R.F.D. WORTON MD</b>			
24. FUNERAL DIRECTOR <b>Kenneth Wally</b>						25a. REC'D BY REGISTRAR <b>Charles Judge</b>			
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>						DATE <b>MAY 10 1966</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>-Kent</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> c. LENGTH OF STAY IN 1b <b>19 1/2 hours</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Kent &amp; Queen Anne's Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Centreville</b> d. STREET ADDRESS <b>RD #1 Box 82</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Audrey</b> First <b>Jane</b> Middle <b>Nelson</b> Last			4. DATE OF DEATH <b>5</b> Month <b>18</b> Day <b>1966</b> Year			5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cashier - DelMarVA Power &amp; Light Co.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Talbot Co., Maryland</b>			9. AGE (in years last birthday) <b>25</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Howard Wesley Boyles</b>					14. MOTHER'S MAIDEN NAME <b>Mary Catherine Thompson</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>212-40-9172</b>		17. INFORMANT <b>Hospital Records</b> Address <b>Chestertown, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Postoperative Neurogenic Shock</b> DUE TO (c) <b>Ventricular fibrillation</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>5 hrs</b> <b>4 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Pneumothorax, ? Spontaneous</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from <b>5/17</b> , 19 <b>66</b> , to <b>5/18</b> , 19 <b>66</b> , that (1) (we) last saw the deceased alive on <b>5/18</b> , 19 <b>66</b> , and that death occurred at <b>3:20 P.M.</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Dr. O.S. Gulbrandsen</b>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>5-20-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. O.S. Gulbrandsen</b>			22d. ADDRESS <b>Chestertown, Maryland</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>May, 22, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sudlersville Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Sudlersville, Q.A.Co; Md.</b>		
24. FUNERAL DIRECTOR <b>Charles Judge</b>			ADDRESS <b>Millington Md.</b>			25a. REC'D BY REGISTRAR <b>MAY 24 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO NEURAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit should be removed from the certificate and in any event, within 72 hours after death should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <u>Kent</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u> c. LENGTH OF STAY IN 1b <u>11 Yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>xx</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u> d. STREET ADDRESS <u>xx</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Herman</u>			First Middle Last <u>Peterman</u>			4. DATE OF DEATH <u>May</u>		Day <u>14</u> Year <u>1966</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 17, 1884</u>		9. AGE (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Julius Peterman</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>186-09-9401</u>		17. INFORMANT <u>Mrs. Ethel Peterman</u> Address <u>Rock Hall, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> 31X DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Old Age</u>								INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>7-20</u> , 19 <u>64</u> , to <u>May 14</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5-14</u> , 19 <u>66</u> , and that death occurred at <u>10:50 AM</u> , from the causes and on the date stated above.										
22a. SIGNATURE <u>Rudolf S. Relitis</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5-16-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>RUDOLFS RELITIS</u>					22d. ADDRESS <u>Rock Hall, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>May 17</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Northwood</u>		23d. LOCATION (City, town or county) (State) <u>Philadelphia, Penna.</u>			
24. FUNERAL DIRECTOR <u>Edgar L. Lane</u>					ADDRESS <u>Church Hill, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 24 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION



## CERTIFICATE OF DEATH

07058

07049

1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> c. LENGTH OF STAY IN lb <b>8 hours</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Kent &amp; Queen Anne's Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rock Hall</b> d. STREET ADDRESS <b>Skinner's Neck Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Fredrick Theodore Reihl</b>		4. DATE OF DEATH Month <b>5</b> Day <b>26</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/26/66 1892</b>
9. AGE (In years last birthday) <b>74 yrs.</b>		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Kent Co., Maryland</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>US</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Carl NMN Reihl</b>		14. MOTHER'S MAIDEN NAME <b>Augusta unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-09-1303</b>	
17. INFORMANT <b>Hospital Records</b>		Address <b>Chestertown, Md.</b>	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Major cerebral hemorrhage</b> DUE TO (b) <b>Essential hypertension</b> DUE TO (c) <b>Year</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>11 hours</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5/26</b> , 1966, to <b>5/26</b> , 1966, that (I) (we) last saw the deceased alive on <b>5/26</b> , 1966, and that death occurred at <b>7:00 P.M.</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>A.C. Dick</b>		22b. DATE SIGNED <b>5-28-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. A. C. Dick</b>		22d. ADDRESS <b>Chestertown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/30/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>near Rock Hall, Md.</b>
24. FUNERAL DIRECTOR <b>Wells</b>		25. RECEIVED BY REGISTER <b>1966</b>	
26. FUNERAL DIRECTOR'S SIGNATURE <b>Wells</b>		27. REGISTER'S SIGNATURE <b>Wells</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





C7053

## CERTIFICATE OF DEATH

C7050

1. PLACE OF DEATH a. COUNTY <b>Kent</b>		b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN 1b <b>26 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Kent</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		d. STREET ADDRESS <b>536 High Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <b>Hallie (COOPER) Simpson</b>		4. DATE OF DEATH Month Day Year <b>5/20/ 19 66</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>2/13/94</b>		9. AGE (In years lost birthday) yrs <b>72</b>		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Kent, Co., Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>US</b>													
13. FATHER'S NAME <b>Samuel E. Cooper</b>								14. MOTHER'S MAIDEN NAME <b>Margaret A. Patrick</b>																	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO <b>579-38-9914</b>				17. INFORMANT <b>Hospital Records</b>				Address <b>Chestertown, Md.</b>													
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Myocardial decoup</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial infarction</b> DUE TO (c) <b>ASCVD</b>												INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b>													
												PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic renal failure - Cholelithiasis</b>													
												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)																					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)													
21. I certify that (I) (this hospital) attended the deceased from <b>4/24</b> , 19 <b>66</b> , to <b>5/20</b> , 19 <b>66</b> , that (I) (we) lost saw the deceased alive on <b>5/20</b> , 19 <b>66</b> and that death occurred at <b>10:20 A.M.</b> M, from causes and on the date stated above.																									
22a. SIGNATURE <b>Harry P. Ross</b>								ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <b>5-21-66</b>													
22c. PHYSICIAN'S NAME (Type) <b>Dr. Harry P. Ross</b>								22d. ADDRESS <b>Chestertown, Maryland</b>																	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>5/22/66</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Chester Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>Chestertown, Md.</b>													
24. FUNERAL DIRECTOR <b>J. Wells Wells</b>								ADDRESS <b>Chestertown, Md.</b>				25a. REC'D BY REGISTRAR <b>MAY 24 1966</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. In please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
07060								07051	
1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> c. LENGTH OF STAY IN 1b <b>4 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Kent &amp; Queen Ann's Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sudlersville</b> d. STREET ADDRESS <b>17-2</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Irene</b> Middle <b>Gertrude</b> Last <b>Townsend</b>					4. DATE OF DEATH Month <b>5</b> Day <b>19</b> Year <b>19 66</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/31/96 1897</b>		9. AGE (In years last birthday) <b>69 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Andrew Gillen</b>					14. MOTHER'S MAIDEN NAME <b>Elizabeth ODay</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>217 36 0918</b>		17. INFORMANT <b>Hospital Records</b> Address <b>Chestertown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Anemia - cause unknown but due probably to intra-abdominal neoplasm</b>									INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)			20g. (City or town) (County) (State)			20h. (City or town) (County) (State)			20i. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5/15</b> , 19 <b>66</b> , to <b>5/19</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5/19</b> , 19 <b>66</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Dr. Robert W. Farr</b>					22b. DATE SIGNED <b>5/20/66</b>			22c. PHYSICIAN'S NAME (Type) <b>Dr. Robert W. Farr</b>	
22d. ADDRESS <b>Chestertown, Maryland</b>					22e. ADDRESS <b>Chestertown, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>5/23/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chester Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Chestertown, Md.</b>	
24. FUNERAL DIRECTOR <b>J. Willis Wells</b>					25a. REC'D BY REGISTRAR <b>MAY 24 1966</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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\* *proced. 4.1.10*

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$$L_{\infty}(\mathbb{R}^n; \mathbb{R}^m) \rightarrow L_{\infty}(\mathbb{R}^n; \mathbb{R}^m)$$

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## References

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

2556

Fig. 10. (a)  $\sigma_{xx}$  and (b)  $\sigma_{yy}$  contours.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07061

CERTIFICATE OF DEATH

07052

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>			c. LENGTH OF STAY IN 1b <b>13 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Betterton</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kent &amp; Queen Anne's Hospital</b>				d. STREET ADDRESS <b>None</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mabel J. Vickroy</b>				4. DATE OF DEATH Month Day Year <b>5 19 19 66</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/27/1893</b>	
9. AGE (In years lost birthday) yrs. <b>72</b>		10. IF UNDER 1 YEAR Months Days <b>14 1</b>		11. IF UNDER 24 HRS. Hours Min. <b>19 66</b>		12. IF UNDER 24 HRS. Hours Min. <b>19 66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Georgia</b>	
13. FATHER'S NAME <b>Hoyle Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Mary Watts</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-48-4204</b>		17. INFORMANT <b>Hospital Records</b>		Address <b>Chestertown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro Pulmonary Shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Anterolateral Myocardial Infarction</b> DUE TO (c) <b>Pulmonary Infarction</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>14 DAYS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary Infarction</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5/19 5/6</b> , 19 <b>66</b> , to <b>5/19</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5/19</b> , 19 <b>66</b> , and that death occurred at <b>12:45 P.M.</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Thomas J. Solon</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5-20-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Thomas Solon</b>				22d. ADDRESS <b>Chestertown, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5-23-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>STILL POND CEMT</b>		23d. LOCATION (City or Town) (County) (State) <b>STILL POND, KENT, MD.</b>	
24. FUNERAL DIRECTOR <b>Victor N. Kennedy</b>				ADDRESS <b>STILL POND, MD.</b>		25a. REC'D BY REGISTRAR <b>MAY 23 1966</b>	
						25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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